Arboviral Case Investigation Form

County/IHS ID number:

State ID Number

Patient's name (Last) (First) (Middle Initial)

Diagnosis at presentation:

- ☐ Uncomplicated Fever
- ☐ Meningitis
- ☐ Encephalitis
- ☐ Asymptomatic
- ☐ Viremic Blood Donor
- ☐ Other:_____

Patient hospitalized?

- ☐ Yes, Admit date: ___/___/____
- ☐ No

Is patient breastfeeding a child?

- ☐ Yes
- ☐ No

Is patient a breastfed child?

- ☐ Yes
- ☐ No

Past medical history:

- ☐ Cancer
- ☐ Diabetes: type: _____
- ☐ Viral Hepatitis
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Immunosuppressive Condition
- ☐ Pulmonary Disease
- ☐ Mosquito-borne illness: Dengue, Yellow fever, Japanese encephalitis, WNV, SLE, flavivirus

Symptoms (Check all that apply – circle primary symptom):

- ☐ Headache
- ☐ Fever (> 38ºC or 100ºF)

Max. temp. :_____

- ☐ Neck pain/stiffness
- ☐ Arthralgia or Myalgia
- ☐ Photophobia
- ☐ Rash
- ☐ Seizure
- ☐ Lymphadenopathy
- ☐ Tremors
- ☐ Extreme fatigue
- ☐ Nausea/vomiting/diarrhea
- ☐ Shortness of breath
- ☐ Flaccid paralysis
- ☐ Spastic paralysis
- ☐ Profound muscle weakness
- ☐ Altered mental status
- ☐ Unconsciousness
- ☐ Other – *specify*: _____

_____

_____

Vaccination history:

- ☐ Yellow fever Date: ____/____/____
- ☐ Japanese encephalitis Date: ____/____/____
- ☐ Tick-borne encephalitis Date: ____/____/____

Risk factor assessment:

Within 14 days of onset of symptoms, did the patient…

1) have known mosquito exposure? ☐ Yes ☐ No

Date: ____/____/_____ Location:_____

Date: ____/____/_____ Location:_____

2) travel outside county of residence? ☐ Yes ☐ No

Dates From:____/____/_____ To: ____/____/_____

Location: _____

Dates From:____/____/_____ To: ____/____/_____

Location: _____

3) travel outside Arizona? ☐ Yes ☐ No

Dates From:____/____/_____ To: ____/____/_____

Location: _____

Dates From:____/____/_____ To: ____/____/_____

Location: _____

4) travel outside US ? ☐ Yes ☐ No

Dates From:____/____/_____ To: ____/____/_____

Location: _____

Dates From:____/____/_____ To: ____/____/_____

Location: _____

5) donate blood? ☐ Yes ☐ No

Date: ____/____/_____

6) donate an organ or tissue? ☐ Yes ☐ No

Date: ____/____/_____

In the 30 days prior to onset of symptoms:

7) did the patient receive blood or blood product? ☐ Yes ☐ No

8) did the patient receive an organ or tissue transplant? ☐ Yes ☐ No

Contact or person providing patient information, if other than patient:

Name:_____ Telephone:_____ Relationship:_____

Please FAX above information as soon as completed to: ADHS VBZD Section – 602-364-3199 or 602-364-3198

Acquired:

in utero?	☐ Yes	☐ No
in a laboratory?	☐ Yes	☐ No
occupationally (non lab)?	☐ Yes	☐ No

Length of Illness: _____ days Date of discharge , if hospitalized: ____/____/_____

Outcome:

- ☐ Died Date: ____/___/_____
- ☐ Full Recovery
- ☐ Recovery with sequelae (describe):_____

_____

Treatment (check all that apply):

- ☐ Immunoglobulin
- ☐ Antiviral
- ☐ Interferon
- ☐ Supportive care only
- ☐ None

Case Classification:

- ☐ Confirmed case
- ☐ Probable case
- ☐ Suspect
- ☐ Ruled out/ Non case

Case acquisition:

- ☐ Out of county
- ☐ Out of state
- ☐ Out of US
- ☐ Unknown

Investigator: _____ **Date initiated** ____/____/_____ **Date completed:** ____/____/_____